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**Safeguarding Adults Review (SAR)**

**Subject: M22**

**Final Overview Report**

**SAR Independent Author: Peter Suggett**

*Nottinghamshire Safeguarding Adults Board wishes to place on record its sincere thanks to the family of Adult M who worked closely with the Board and Independent Reviewer and Author. They provided valuable information and an insight into the life of Adult M which was used to help shape and inform this review. This Safeguarding Adult Review would not have been possible to undertake without the co-operation, open reflection and information supplied by those agencies who provided care and support for Adult M. This contributed significantly to the production of the final report and helped to identify recommendations for improvement. The input and professional support provided by the Safeguarding Adults Board managers and support staff have been invaluable throughout this process.*

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| 1 | Introduction and Background |
| 1.1 | Section 44 of the Care Act 2014 places a statutory responsibility on Safeguarding Adult Boards’ (SAB) to conduct a Safeguarding Adult Review (SAR) into certain cases under certain circumstances. A SAB is required to arrange a Review where there is reasonable cause for concern about how the SAB, and its members or some other person with relevant functions involved in the case worked together and, either the adult at risk died and the SAB knows or suspects that the death resulted from abuse or neglect. Or, the adult is alive, and the SAB knows or suspects that they experienced serious abuse or neglect. |
| 1.2 | The Nottinghamshire County Council Safeguarding Adult Board has accepted the request for a Safeguarding Adult Review (SAR) to be conducted into the circumstances surrounding the death on 10th April 2022 at Kings Mill Hospital, Nottinghamshire of Mr M22. At the time of his death Mr M22 was 44 years of age. |
| 1.3 | The SAR panel agreed that the situation met the Care Act Safeguarding criteria for a SAR; specifically, the criteria that procedures may have failed and that the case gave rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk. |
| 2 | The Purpose of the Review |
| 2.1 | * Establish what lessons can be learned from the circumstances of the case * Review the effectiveness of the procedures and processes of the agencies involved * Analyse how organisations work together * Analyse and expand upon the findings of the various reports * Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes or policy * Facilitate a practitioners event to enable professionals to review the findings of the SAR and identify ways in which the recommendations can be developed and implemented |
| 2.2 | This specific SAR is to consider if or how organisations, individually and collectively, may have worked better to correctly assess the needs of Mr M22 whilst he was receiving treatment in the weeks and months prior to his death on 10th April 2022. |
| 2.3 | The SAR will also consider the effectiveness of the Carers assessment completed as part of his needs assessment. Was it correctly undertaken and evaluated and was Mr M22’s son an appropriate person to act as his carer? |
| 2.4 | Finally, the SAR will consider, based upon responses from the organisations involved, if there are gaps in the service delivery for adults which can be identified from this case. |
| 2.5 | Partner reports were received from each of the organisations involved, a template was provided which included the following details:   * Full chronology * A narrative of service involvement- between the dates of 2019 and 10th April 2021. * A description of the specific service provided to Mr M22 between those dates. * Any significant factors which impacted upon the actions or decisions taken. * An evaluation of how services were delivered to Mr M22. * Lessons learned including a judgement of the level of service received when compared against policy, procedure and practice standard. * Recommendations for action. |
| 3 | Methodology and Process Information |
| 3.1 | The author was appointed to undertake the SAR in October 2022. |
| 3.2 | Combined chronologies were supplied to the author along with a review completed by a safeguarding adult lead from one of the organisations involved. The agencies involved included:   * Nottinghamshire Healthcare NHS Foundation Trust * Adult Social Care * Ashfield District Council – Housing department * Children’s Social Care * East Midlands Ambulance service * Nottinghamshire Clinical Commissioning Service * Nottingham Universities Hospitals NHS Trust * Sherwood Forest Hospitals NHS Trust |
| 3.3 | Through the use of an intermediary, communication was facilitated between the SAR author and Mr M22’s son. With his consent, the author wrote to Mr M22’s son and submitted a number of questions relating to his experiences and asked for his opinion on the treatment his father received prior to his death. |
| 3.4 | He was able to supply a substantial amount of background information about Mr M22 and was keen to put forward the family’s perspective about the treatment he had received. |
| 3.5 | Following the initial review of all the information, a number of themes were identified that the author considered were key elements of the care Mr M22 received prior to his death. These fell into the following categories:   * Partnership working * Supervision and support * Risk management * Self neglect * Carers assessment |
| 3.6 | A practitioner learning event was held on 28th September 2023. This event involved both front line and management staff and was facilitated by the report author. In order to allow the maximum number of staff to participate in the event it was run via Microsoft Teams. |
| 3.7 | It was made clear at the outset of the learning event that it was to be conducted in an environment where staff would feel free to express themselves, without fear of being blamed for any apparent failings. The intention was to learn from the circumstances of Mr M22s treatment in order to identify those elements that worked well and highlight areas that required further improvement. |
| 3.8 | The combined chronology and an explanatory letter were circulated to all participants prior to the event so that everyone was clear about the aims and objectives. In addition, the viewpoint of the family was shared with the delegates as part of a section entitled ‘Getting to know Mr M22’. |
| 3.9 | The event involved a summary of the timeline of events leading up to Mr M22’s death, followed by a series of questions which the participants were asked to comment upon relating to the five themes previously identified. |
| 3.10 | Delegates were asked to consider the circumstances of Mr M22’s death and, when thinking about a particular categories, consider:   * What went well? * Even better if … * How to improve learning |
| 3.11 | There was excellent participation from all candidates during the session and a number of key issues were highlighted and discussed.  These are described in more detail within the body of this report. |
| 4 | Background |
| 4.1 | Mr M22 was born on 10th April 1978. |
| 4.2 | He spent most of his life living in and around Sutton-in-Ashfield, Nottinghamshire. He had well documented issues in his life involving substance misuse and these impacted upon his physical health. |
| 4.3 | The chronologies provided by key agencies detail Mr M22’s medical history going back to the start of 2018. What can be seen from the information available is that he had complex medical needs. These included peripheral vascular disease, as well as a number of problems associated with alcohol and drug use. |
| 4.4 | Prior to 2018 the records indicate that Mr M22 had been provided with a great deal of support from a number of services including Alcohol Support, Parenting Programme, local Adult Mental Health teams as well as support from a Dietician and help from both Occupational Therapy and Physiotherapy teams. |
| 4.5 | In order to better understand the interactions between the various agencies and departments involved in the care of Mr M22, the author produced a combined chronology. This provides a timeline of events and describes the contact and care that took place prior to his death. Some of key entries are summarised below. |
| 4.6 | Mr M22 was supplied with accommodation via an arrangement with Nottinghamshire County council. |
| 4.7 | In 2015 there is a great deal of interaction with Mr M22 and his partner with children’s services regarding the apparent neglect of their children. This was resolved when the two younger children were adopted, whilst the eldest child (16yrs at that time) remained in the home. |
| 4.8 | In 2017 there were ongoing concerns recorded in relation to Mr M22’s diet and weight, as well as issues around his mental health. He received help via his GP in relation to his diet as well as alcohol and cannabis use. |
| 4.9 | 22.02.18 Nottingham University Hospital. Mr M22 was admitted for vascular surgery due to left leg pain, ischaemic left leg, reduced sensation and motor function. He underwent a left high above knee amputation and right leg fasciotomy. Following this he had a prolonged stay in critical care. He was discharged on 05.04.18 with follow up arranged. |
| 4.10 | In November 2019 his relationship with his partner broke down. She then vacated the family home, leaving Mr M22’s son at the address acting as his carer. |
| 4.11 | In April 2021 an Occupational Therapist (OT) fully assessed Mr M22 and identified that major adaptations were necessary at his home. This was because Mr M22 was sleeping on a hospital bed in the living room. For the previous three years he had been unable to access the upstairs part of his home and had been reliant upon his son for care and support. |
| 4.12 | Within this meeting Mr M22 had stated that since his operation he forgot a lot of things and relied upon his son for his day to day care. He had been told by the council that he was going to be moved but had been waiting three years for this to happen. A Care and Support Assessment (CASA) was requested to establish the amount of support that was required. |
| 4.13 | 12.05.21 a social worker visited Mr M22 at his home address to complete an assessment with him and his son. The financial charge for care was explained and he was provided with the NCC factsheet on "Paying for Care". Mr M22 explained that he struggled with reading and writing but his son would support him with this. After the assessment Mr M22 and his son were advised to decide what support they felt was required and specifically if Mr M22’s son needing to step back from his caring role immediately, or was there a need for some respite? |
| 4.14 | 02.06.21 Mr M22 contacted Social services and informed them that he did need support, especially to give his son a break and a "life". Mr M22 said he could not read and his son had offered to help. It was agreed that the social worker would contact Adult Care Financial Services (ACFS) to see if they can visit to support with completing the form. |
| 4.15 | Mr M22 said that he was struggling with his mental health, he wasn’t sleeping, so he couldn’t get up in the morning and by the time he rang the GP all the appointments were gone. He explained that he was having thoughts about self harm, but declined the number for Samaritans. The Social Worker agreed to contact the GP. |
| 4.16 | 10.06.21 in a follow up call from the Social Worker Mr M22 said he didn't feel able to bring up his mental health in his conversation with the GP because it was a quick appointment. He had the contact number for Insight Mental Health whom he would self-refer too. It was explained that the GP could still be contacted. |
| 4.17 | 10.06.21 A Carers information pack was sent out to Mr M22’s son and there was ongoing communication with regard to Mr M22 moving to a more appropriate property. |
| 4.18 | 16.06.21 The GP reviewed Mr M22’s mood following concerns raised by adult social care. |
| 4.19 | 18.06.21 Social Worker home visit - Carers Assessment was completed with Mr M22 son. A request was made for support twice a week for personal care, social support and support with domestic tasks. Mr M22 did not want to go into a care home but was interested in having more support during the day so his son could go on a short break. It was noted that the property smelled strong of cannabis and Mr M22 said he used cannabis daily for pain relief due to his amputation. |
| 4.20 | 18.06.21 follow up call to GP from Social Worker to explain that Mr M22 is struggling with pain management and is using cannabis daily to control his pain. The GP attempted to contact Mr M22 but there was no answer, a message was left to contact surgery. |
| 4.21 | Various applications were then made to identify a service that would be able to fulfil Mr M22’s care package. It was agreed that Mr M22’s son would continue to be his primary carer until they were able to move into more appropriate accommodation, at which time Mr M22 would be able to be more independent. Mr M22’s son expressed some concerns about his father’s behaviour when he had been drinking, stating that he could be *‘erratic’* and that he sometimes fell out of bed. Arrangements were made for Mr M22 to be supplied with a lifeline. |
| 4.22 | 25.10.21 Mr M22 attended the GP with bruising to both lower leg stumps. The GP diagnosed phantom limb pain and referred Mr M22 to the pain clinic and arranged blood tests. |
| 4.23 | 27.10.21 Mr M22 attended the accident and emergency department at Kings Mill hospital where he had blood tests and was diagnosed with cellulitis and prescribed antibiotics. |
| 4.24 | 16.11.21 There was a telephone consultation with the GP due to concerns about bruising at the top of the legs. The GP arranged a face to face consultation. |
| 4.25 | 19.11.21 Mr M22 advised that he had been provisionally offered an adapted property that he was due to view later in the month. |
| 4.26 | 22.11.21 Mr M22 attended the GP with continuing discharge from his wounds. Upon examining him it was noted that he had wounds to the right scrotal area and at the back of the right leg stump. There was some discharge and crusting but no signs of spreading infection. He had some bruising which the GP suspected was due to the clopidogrel (a blood thinner) that Mr M22 was taking at the time. The doctor advised Mr M22 to continue taking the clopidogrel and prescribed a course of doxycycline (an antibiotic) and referred him to the practice nurse for dressings. |
| 4.27 | Between 22nd November and 6th December Mr M22 attended the practice nurse or health care assistant on seven occasions to get his dressings changed. |
| 4.28 | 08.12.21 The GP liaised with Tissue viability nurse and made a referral to the vascular surgical team for advice and support with on-going skin damage. A new course of painkillers was prescribed. |
| 4.29 | 17.12.21 The Tissue Viability Service received a referral for support regarding the management of lesions. Photographs of the wounds were reviewed and concerns were raised of suspicious pathology. Advised an onward referral to dermatology and a request for the practice nurse to liaise with Mr M22. |
| 4.30 | 21.12.21 Mr M22 missed a vascular outpatients’ appointment at Kings Mill hospital. |
| 4.31 | Mr M22 reported to the Occupational Therapist that he was experiencing pain in his right stump and had what felt like bruises around his stump radiating around the back of his right hip. He also reported a burning sensation around his right stump, which on observation had a wound to the right side of his stump which appeared red. This wound had been present for some time, but Mr M22 was concerned that his pain was increasing and changing to a burning sensation. Mr M22 reported that he was drinking regularly, that his appetite was poor and that this was due to suffering from significant pain. The OT agreed to raise the concerns with his GP. |
| 4.32 | 22.12.21 The Tissue Viability Service received contact from OT over growing concern in relation to Mr M22’s pain and discomfort. No contact had been established with Mr M22 via the practice nursing team. The OT advised they would personally escalate to the GP and request an urgent referral. |
| 4.33 | 22.12.21 The Tissue Viability confirm to the GP that they are involved. An Email was sent to Tissue Viability by the OT to update them about concerns raised from today’s visit regarding pain and redness around wound. |
| 4.34 | 23.12.21 A referral was made to dermatology at the request of the tissue viability nurse. |
| 4.35 | 24.12.21 The Tissue Viability Service reviewed Mr M22’s case and noted that the GP had completed the recommended referral to dermatology. There was identification of non-blanching pressure damage and so a recommendation was made for a specialist mattress and to review again in one month. |
| 4.36 | During this period Mr M22 had contact from a Tenancy Sustainment Officer (TSO) about his anticipated move to his new property and specifically any assistance he would require in order to achieve the move. |
| 4.37 | 04.01.22 Mr M22 attended the Dermatology service for ulcerating wounds to his left thigh due to severe peripheral vascular disease. |
| 4.38 | On 05.01.22 and 12.01.22 Mr M22 attended the practice nurse for wound dressing. |
| 4.39 | 08.01.22 Adult Integrated Care referral received. Home visit made however no treatment was given as no dressings were present. It was noted that three visits were booked with the Practice nurse for the following week and Mr M22 was therefore discharged from the service as he was not considered to be house bound. |
| 4.40 | 12.01.22 GP - Reviewed at request of primary care health visitor. The GP advised that Mr M22 required IV anti-biotics. An ambulance was arranged, and he was transferred to Kings Mill hospital |
| 4.41 | 19.01.22 Mr M22 was transferred from Kings Mill Hospital to Nottingham University Hospital, he had presented with an ischaemic right above knee amputation stump and infected ulcers. He was treated with IV antibiotics, provided with wound care and underwent debridement of the wounds. The initially plan was for Mr M22 to undergo a procedure to improve blood flow in his arteries (endarterectomy), but this was reviewed and deemed unsuitable due to long standing risk factors. |
| 4.42 | Mr M22 received nutritional support while an in-patient and upon discharge was prescribed a month’s supply of Scandishake. Information was shared with the GP with a request for follow up in the community, this included a referral to the community dietitian if deemed appropriate by the GP. Staff felt that an assessment of his care and support needs would be appropriate due to his ongoing nutritional needs, however this was declined by Mr M22, he was deemed to have capacity to make this decision. |
| 4.43 | During this period Mr M22 received the keys to his new property and Mr M22’s son made arrangements for their belongings to be moved to the new home. |
| 4.44 | Prior to discharge Mr M22 was reviewed by OT and physiotherapist. OT liaised with Kings Mill Hospital amputee rehab team to review his wheelchair cushion which was not essential for discharge. He was deemed medically fit for discharge on 09.02.22. A district nurse referral was made to provide support with management of wounds to his natal cleft, hips and stump. |
| 4.45 | 26.01.22 Home visit by OT to the new address. The move occurred on Sunday 23.01.22. |
| 4.46 | 10.02.22 Adult Integrated Care: referral accepted for District Nurse services. |
| 4.47 | 11.02.22 Adult Integrated Care: referral sent to amputee team, home visit undertaken, Body maps completed, wounds measured, environmental risk assessment undertaken, fire risk assessment completed, fire service referral completed, SSKIN bundles completed, BESTSHOT performed, Holistic assessment completed, Braden assessment complete, MUST completed, Images taken and uploaded of wounds, dressings undertaken. |
| 4.48 | 11.02.22 Urgent Response and Therapy (URT): Home visit attended in relation to completing a transfer assessment, observed transfer from bed to wheelchair, difficulty raised in relation to toilet transfer, advised commode. Reported to have been smoking cannabis prior to visit. |
| 4.49 | On 11.02.22 Mr M22 attended the dietician to improve nutritional intake to promote wound healing. |
| 4.50 | 15.02.22 Adult Integrated Care (AIC) home visit attended. Mr M22 reported not to be happy with previous nurse as they were too rough and left a wound exposed. He was experiencing some pain but not as much as other times. Wound care completed. |
| 4.51 | On 16.02.22 Mr M22 was reviewed by the Occupational Therapy Amputee Team at home. |
| 4.52 | 17.02.22 Tissue Viability Service contacted with concerns raised in relation to Mr M22 being discharged with no long-term plan in place. There were also concerns about his only carer being his son, who has learning difficulties and is worried that the burden is too great for him, and who may not recognise a need for escalation in time. Concerned re-admission may be required and highlighted the risk of sepsis. |
| 4.53 | 17.02.22 TVS: Specialist Tissue Viability Nurse assessment completed, joint visit with AIC. Mr M22 appeared very unwell; physical observations completed. Concern were raised in relation to infection and Mr M22 was advised he required admission to hospital. Mr M22 refused admission expressing that he felt let down by the hospital and that he should not have been discharged previously. The GP was contact who advised admission. A mental capacity assessment was completed and Mr M22 was deemed to have capacity to decide whether he attended hospital or not. Mr M22 was made aware he could die from his wounds. Mr M22s son was encouraged to discuss this with his father and to monitor Mr M22 for worsening symptoms and to call 999 should he deteriorate. His wounds were assessed and dressed, equipment was ordered from the Red Cross, Braden Scale completed, alternate day visits recommended at minimum. |
| 4.54 | 17.02.22 GP - Tissue viability nurse contacted GP worried about clinical presentation. The GP and tissue viability nurse agreed that Mr M22 needed admission. The GP spoke via phone with Mr M22 and tried to encourage him to go into hospital, however Mr M22 was distressed and refusing the request. The GP agreed to call back later and spoke with Mr M22’s son at 17:55. Mr M22’s son stated that Mr M22 was willing to go into hospital the following day. The GP strongly advised that he should go as soon as possible due to risk of sepsis and death. The GP prescribed antibiotics in the meantime. Mr M22’s son was happy with the plan. |
| 4.55 | 18.02.22 East Midlands Ambulance Service were requested by the GP to transport Mr M22 from home to Kings Mill hospital due to bilateral infected leg ulcers. On arrival the crew weighed Mr M22, which they recorded as 27.6kg. EMAS transported Mr M22 to Kings Mill hospital, however upon arrival Mr M22 refused to have his wounds seen or examined. He was assessed as having the mental capacity to make this decision. He was discharged on a course of oral antibiotic (Doxycycline). |
| 4.56 | 22.02.22 Occupational Therapist visited Mr M22 and observed that he was in bed on arrival and took a while to respond but did manage to use the profiling bed to sit up. He appears even thinner and weaker than when previously seen some weeks before. Mr M22’s son expressed concerned that he was having to assist his Dad more than he had previously. Mr M22 was able to transfer onto his wheelchair and wheel himself to the shower room and back to his bed. Mr M22 advised that he is being seen by the district nursing team every two days to attend to his leg, but no surgery was possible due to his loss of weight increasing the risks. Mr M22 stated that he did not wish to go back into hospital. |
| 4.57 | At 12.55hrs the duty Social Worker was contact by the OT from Forest Hospitals trust requesting an assessment for support for Mr M22, as Mr M22’ son has voiced concern that he is struggling with his Dad's complex needs. At 16.00hrs the social worker called Mr M22’s son to discuss the concerns raised. There was no reply and a message was left. |
| 4.58 | On 23.02.22 Social workers held a meeting to discuss the issue that Mr M22’s son is requesting support with caring for his father after the OT voiced concerns. The case was allocated to a social worker on 23.02.22 to plan a visit to see Mr M22 and his son regarding further support as Mr M22’s health needs have increased. Mr M22’s son wanting to cease being his full time carer. Mr M22’s son did not respond to a telephone call by duty social worker about the initial referral on 22.02.22. |
| 4.59 | Despite numerous attempts to contact Mr M22, and a personal visit to his home, the social worker was unable to meet with Mr M22 or his son. |
| 4.60 | 07.03.22 Adult Integrated Car, entry stating that Mr M22 had been seen out of the house by a member of the team. They were unhappy to discharge him as they felt they should be considering palliative care for Mr M22. Awaiting instruction from GP. |
| 4.61 | 21.03.22 The Tenancy Sustainment Officer (TSO) visited Mr M22 at his home, his son was also present. Mr M22 was in a hospital bed. Mr M22 pulled himself up to speak to TSO. TSO asked Mr M22 how he was doing as he looked frail and on occasion moaned as he moved. Mr M22 said he was ok and felt that his infection was now responding to treatment. Mr M22 son stated the district nurse was now coming outevery other day. |
| 4.62 | Telephone consultation with the GP on 25.03.22 due to ongoing pain in his leg stumps. The GP noted that Mr M22 was still under the care of the Tissue Viability Nurses, and prescribed Oramorph (a painkiller) and Zomorph (a pain killer). |
| 4.63 | There a number of home visits which occur within this period which would appear to have involved routine dressing and wound care. No mention is made of any deterioration of Mr M22’s health. |
| 4.64 | On 04.04.22 the GP was contacted by the community nurse who reported that they had attended Mr M22’s home and that he looked very ill. He was refusing to have his dressing changed/wound care and refusing food and water. The GP advised that the community nurse should contact his son and also refer to hospital via a 999 ambulance. |
| 4.65 | On 08.04.22 Adult Integrated Car attended the address and were unable to gain access or contact Mr M22 or his son. |
| 4.66 | Following a 999 call on 09.04.22 by Mr M22’s son, EMAS were dispatched to the home. There they found Mr M22 to be very poorly and barely responsive and recorded that he weighed 20.4 kg. EMAS then took Mr M22 to hospital. |
| 4.67 | On 10.04.22 Mr M 22 sadly died in Kings Mill Hospital. The coroner subsequently recorded the cause of death as being sepsis. |
| 5 | Summary of Events and Findings |
| 5.1 | Having reviewed the chronologies, what is clearly apparent is that there was a large amount of good work taking place to help and support Mr M22, from a number of different agencies. This activity occurs every day within the care setting and is undoubtedly successful in the majority of patients. Clearly, the rate of success is greater when the patient is co-operative and a good communicator, but is less effective when they are not as receptive to the offers of support. This then makes the situation more challenging for the professionals involved. |
| 5.2 | From both the laypersons and professionals’ perspective an obvious question to ask would be, who is co-ordinating and leading all of this activity? The hospital wards have a responsibility to ensure that information is passed onto community services, including district nurse and community Occupational Health and Physiotherapy, and again on the whole this system works well. However, it only requires one small breakdown in communication, or a lack of grip and a vulnerable person could easily fall through the net. This appears to be what happened with Mr M22. |
| 5.3 | A summary of findings for each of the key themes identified is outlined below. |
| 5.4 | **Partnership working** |
| 5.5 | What became apparent during this review is the fact that there is no single department that co-ordinates this system of partnership/multi agency working. The system is reliant upon hospital/acute staff passing on referrals to the right community service, who then implement their activity. If this is not done correctly there is the risk that the community service is unaware that they need to provide care/support to a patient within their area. This can lead to vulnerable patients lacking the necessary support. In addition, acute services do not automatically notify the community services when a patient is admitted to hospital. |
| 5.6 | This was made even more evident during the course of the practitioners learning event, when one participant stated that they had not realised that many of the different agencies gathered for the event had been involved in the care of Mr M22. |
| 5.7 | The ideal solution would involve a single point of contact to co-ordinate all of the community and hospital services. This would appear to fall within the remit of the GP and it was noted from the records that a great deal of the regular co-ordination did appear to go through the GP surgery. On the whole this appeared to be successful, but it became clear from examination of the timelines that the GPs often had to make frequent attempts to get in contact with Mr M22 and he did not answer his phone, or respond to messages, for long periods of time. |
| 5.8 | A specialist Single Point of Contact team could be created to co-ordinate this activity, however it is accepted that this would be very difficult to arrange and ultimately constrained by budgetary considerations. |
| 5.9 | **Supervision/Support to staff** |
| 5.10 | The level of supervision and support given to staff should be commensurate with the type of work being undertaken when considered against the experience and quality of the staff involved. |
| 5.11 | A very good post incident review was completed by one of the service managers, which assessed and evaluated the contact between Mr M22 and community staff prior to his death. |
| 5.12 | The report identified that there had been some good multi agency working that had taken place, but also that there were some missed opportunities to engage. A question that was raised was whether this was as a result of staff being too ‘*task orientated’*. In addition, it was observed that time constraints and staffing levels also have an impact upon the quality of care provided. |
| 5.13 | Practitioners from the community nursing team shared at the learning event that the level of staffing during the period under review was at a ‘critically low level’ and had been for some time. However, despite this Mr M22 did not have a missed visit appointment or deferred appointment. Staff shortages were, and remain, on the Trust’s Risk Register. |
| 5.14 | A lack of consistency will undoubtedly impact upon the quality of the outcomes. Staff who form a relationship with patients over a period of time are better placed to assess their wellbeing than those who are backfilling vacancies or are agency or bank staff. |
| 5.15 | When staff are working under pressure and there is a lack of consistency in worker due to staffing challenges this may impact their ability to see the wider picture and identify issues such as self-neglect. |
| 5.16 | **Self neglect** |
| 5.17 | Clearly Mr M22 had complex medical needs. In addition, there seems to be clear evidence to suggest that he was suffering at times from possible sepsis/infections. An obvious question that arises from that is, did this level of infection result in any form of mental impairment /delirium which may have impacted upon his ability to make decisions? |
| 5.18 | There is nothing within the material supplied to the author to suggest that this was the case, but there were also occasions where Mr M22 refused treatment (admission at A&E) and also refused to have dressings changed, when clearly there would have been a need to do so. |
| 5.19 | As such, during those episodes the question that arises is did he have the capacity to make decisions about his care and treatment? Were medical staff aware of the impact his type of medical condition may have had on his mental function. Allied with that was his apparent difficulty in maintaining a reasonable weight (he was often referred to as underweight) which would appear to further indicate a propensity to self neglect. |
| 5.20 | Perhaps then the issue to be addressed should be; if the system of assessment, referrals and interventions is acceptable for the vast majority of patients, what should be done when professionals are faced with a case that is particularly challenging and falls outside the realms of what might be considered to be ‘usual’? |
| 5.21 | The Mental Capacity Act (MCA) code of practice states ‘*it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made’*. The codes of practice go on to describe that someone’s ‘*behaviour or circumstances may cause doubt as to whether they have the capacity to make a decision’*. A MCA assessment can therefore help to guide the professional in determining if further support is required from a mental health specialist, multidisciplinary panel or even from a family member. |
| 5.22 | It would seem appropriate that in these instances a formal mental capacity act assessment be conducted. Mr M22 had on-going issues relating to infection in his legs and amputation wound sites. These appear to have been further complicated by his poor nutritional state, which may have impacted upon his ability to deal with the infections. |
| 5.23 | During one hospital visit it is noted that he was placed on a nasogastric feeding tube to try and assist with his nutrition. Given these risk factors, his previous medical conditions (amputation), weight loss and extremely low body weight, consideration should have been given to conducting a formal MCA assessment and Mr M22 should have been referred to a high risk panel. |
| 5.24 | For reference the author examined the NICE guidelines regarding mental capacity, which provide a clear pathway of assessment. It is clear from admission documentation supplied to the author that MCA forms part of the admissions to all hospitals. In addition, there is clear guidance that this should be an on-going process, not purely confined to the period when a patient is being admitted. There is also additional guidance where it is recognised that a patient may be suffering from delirium. |
| 5.25 | The Care Act 2014 outlines that where an adult has eligible needs, and these include managing and maintaining nutrition, a support plan should set out how these needs can be met. These may involve a number of options including; a care worker going shopping on behalf of a client to get food, assisting with heating up meals, or making a lunch or dinner. Additionally, clients can order cooked food that is chargeable. This also works on a self-referral system that does not have to be accessed via social care. |
| 5.26 | Social care services are means tested for anyone appearing to require this service. If Mr M22 had been assessed as not having to contribute due to his low income then the care service would have been free. The financial status of Mr M22 is not known, however, he appears to have never consented to an assessment or a means test. |
| 5.27 | There does not appear to have been a safeguarding plan documented within the information supplied as part of this review. There was no mention found that staff considered self-neglect as being an issue with Mr M22, or that there would have been any impact on his decision making due to substance misuse or issues regarding his mental health. |
| 5.28 | Safeguarding policies for adults at risk are available to all practitioners involved in the care of Mr M22 through their own agency and through the Nottinghamshire Safeguarding Adults Board policies and procedures. In addition, the Self Neglect toolkit provides guidance for all agencies. |
| 5.29 | All patients have freedom of choice to refuse treatment or services, but there will sometimes be a point where those rights are overridden in the patient’s best interest. Given his complex health needs, attitude and behaviour and documented weight loss, it seems clear that this was a case where self-neglect was evident and professionals had a duty to intervene in the best interests of Mr M22. |
| 5.30 | **Risk management** |
| 5.31 | It was highlighted during the practitioner learning event that during the period under review, staffing levels amongst the community teams was often at a critically low level. So much so that the situation had been highlighted to the Trust and had been added to the risk register as being a ‘*critical issue’*. |
| 5.32 | One community nursing manager stated during the practitioner learning event that community nursing services were continuously advertising for staff to fill vacancies and that due to shortages and a lack of resilience they were always “*playing catchup*”. |
| 5.33 | Within the initial IMR it was described that staff were too *“task orientated”* in that they were too intent upon satisfying the care plan for individual patients and were not holistic enough in their approach. |
| 5.34 | In essence the conclusion was that it was a case of *“complete the care plan objectives*” and then move onto the next patient? This is undoubtedly a risk when there are insufficient staff who are faced with a large workload. |
| 5.35 | The initial review highlighted that there appeared to be no reference within Mr M22’s clinical records that his case had ever been discussed during supervision, or that senior managers were aware of the complex case. |
| 5.36 | Systems and processes were in place for supervision and clinical oversight, however if staff working with M22 did not recognise the holistic concerns around self-neglect then they may not necessarily escalate concerns or recognise the need for supervision. Since this time the service have improved handovers to promote confirm and challenge and exploration of safeguarding issues.  The author was informed that the trust safeguarding policies are readily available on the internal intranet, as is the self neglect ‘toolkit’ |
| 5.37 | At what point do we over-ride a patient's refusal to be treated? This can be a difficult question for a professional to answer, which is why the system of supervision and support is so important to provide reassurance to staff and to ensure that action is taken which is in the best interest of the patient. |
| 5.38 | Easy access to information and assessment tools (self-neglect toolkit) is vital as part of the ongoing support given to staff within all agencies working with adults at risk, to help them maintain their professional knowledge and understanding of complex safeguarding issues. However, the questions that arise from this are; how many of the staff involved with Mr M22 know where to find this information? If staffing levels are very low do they have time to access and learn the information? Since the death of Mr M22 the community nursing service have introduced weekly micro teaching sessions to provide a protected time for staff to learn, recent sessions included self-neglect, sepsis, Mental Capacity Act (MCA) and documentation. |
| 5.39 | **Carers assessment** |
| 5.40 | As part of the assessment phase of this review, the author was provided with a copy of the carers assessment completed with Mr M22’s son by Adult Social Care. It would appear to be a pro-forma type document detailing how the carer is coping with their role and is designed to assist the assessor with identifying what the carers needs are. This helps the assessor in establishing what level of support is required. |
| 5.41 | Was the son the best person to be M22's designated carer? People agree to undertake these roles despite the fact that they may not be the most suitable person to fulfil the role. This can often be misguidedly done out of a sense of duty or love for the person they are caring for. The question that therefore arises is; was the amount of support provided to Mr M22 and his son sufficient? |
| 5.42 | The carers assessment referred to Mr M22’s son as having learning difficulties and asks if being a carer is having an adverse impact upon his mental health. Whilst the answer to that question affirmed that the role was having an impact upon the mental health of Mr M22’s son, there is no mention within the assessment of how that risk factor was mitigated. The main conclusion from the carers assessment seems to be in relation to the provision of money, so that Mr M22’s son could get some respite by going away for a weekend. |
| 5.43 | Other support had been put in place, which was not included within the carers assessment, or supplied to the author as part of this review. Within the learning event it was disclosed that Mr M22’s son received support from Brighter Futures, which is a support organisation for people with learning difficulties. It was also noted within the Practitioner Learning Event that Mr M22’s son was *‘not the right person’* to care for him, yet he was allowed to carry on in this role. |
| 5.44 | Mr M22 wanted his son to have his own life, however Mr M22’s son did not feel like he could walk away and leave his father in the condition that he was in, and as such he carried on being his carer. |
| 5.45 | Mr M22’s son may not have been the best person to undertake the role, but measures were being taken to further support him. This included help and support from Brighter Futures however, the most beneficial help was the provision of adapted accommodation that would have allowed Mr M22 to live more independently. |
| 5.46 | It was Mr M22’s intention that once he was established within his new home that his son would then have more freedom and could take a step back from being his carer. Unfortunately, Mr M22 died shortly after moving into this new accommodation. |
| **6** | **Service Improvements** |
| 6.1 | There is clearly a need to maintain good communication between different services and agencies. Within the Practitioner Learning Event, facilitated as part of this review, it was apparent that a number of staff present were frustrated with their inability to cross check patient records across different agencies and departments. They stated that this was an ongoing issue which hampered their attempts to provide the comprehensive holistic care they wanted to deliver to their patients. |
| 6.2 | There were frequent examples cited where staff stated that they were unaware that patients they were caring for in the community had been admitted to the hospital, and also that there were frequently delays in them being notifying when those patients were later discharged back to the community. This resulted in time being wasted trying to locate a patient (in the hospital) and community services were not being notified promptly when patients were discharged home. This resulted in a disconnect between the treatment supplied to these patients. |
| 6.3 | The author is aware that other healthcare trusts within England and Wales have introduced Health Information Exchange projects, which have resulted in better information sharing across different agencies. This enables access to joined-up care records providing a view of a patient’s health and care history, current and past medications and a summary of previous events and episodes of care, as well as discharge summaries and clinic letters. |
| 6.4 | There are several limitations with the system (information may not be live), however if something similar had been in place at the time of Mr M22s death it may have assisted professionals with their risk assessments and subsequent decision making. |
| 6.5 | The author is aware that there are now three transfer of care hubs within the system, led by the Integrated Care Board (ICB). Their role is to support patients on wards who may have complex medical and healthcare needs to allow them to be discharged from hospital with adequate help and support. This may involve working alongside other professionals to ensure the patient is discharge to the most appropriate setting for their future care. They are now also able to liaise directly with community and other professional services. Agencies who cared for Mr M22 including the hospital, GP, community services and adult social care all contribute to the transfer of care hubs led by the ICB. |
| 6.6 | During the period under review there did not appear to be a cohesive approach to care planning within the community setting. There is no indication with the records reviewed of any one agency taking the lead in terms of co-ordinating the care given to Mr M22. There does not appear to be a clear decision-making pathway or an individual or agency who took a grip of the situation. If there had been it would undoubtedly have been a great assistance to professionals who were trying to co-ordinate the care and support for Mr M22, both within the hospital setting, but more importantly they would have helped to put a plan in place to support Mr M22 when he was discharged home. |
| 6.7 | Within Community services there is now a weekly complex case multi-disciplinary team discussion. This provides staff with an opportunity to raise any concerns they may have about a patient they may be treating, particularly if they feel that there is an issue for which they need guidance and support. From here managers can escalate cases to the complex case panel so that senior staff from the services involved can assess the risk and devising a plan to progress matters. |
| 6.8 | In addition, the Community Nursing Team handover now includes a discussion around any identified concerns for patients. This includes the reporting of any escalating health or safeguarding concerns to other professionals, whereby they are agreed and actioned with an identified practitioner being allocated. This is then recorded within the patient’s clinical record. |
| 6.9 | There were a number of good learning points highlighted within the chronologies. These included attempts by physiotherapy and occupational therapy teams to engage with Mr M22 to help him mobilise, as well as the district nursing team who provided good care and support to Mr M22. |
| 6.10 | The Tenancy Sustainment Officers spend a great deal of their time visiting people in their homes dealing with issues around housing.  It was noteworthy within the Practitioner Learning Event that they expressed the view that they had a positive relationship with Mr M22, but stated that when they raised concerns about Mr M22’s deteriorating health they felt that they are not listened too. This would appear to be an ongoing concern on their part. |
| 7 | **Recommendations** |
| 7.1 | **Nottinghamshire Healthcare Trust should review the current structure of the community teams to establish if they are correctly resourced to meet the growing demands placed upon the service.** On numerous occasions during the Practitioner Learning Event it was stated that the community services were ‘*under staffed’* during the period reviewed and that this situation still continues today. Staffing levels were noted as continuing to be the subject of an entry on the Trust ‘risk register’ and one of the conclusions of this review is that poor staffing levels may have contributed to staff who cared for Mr M22 taking a task orientated approach to his care and failed to recognise the wider context of self-neglect and therefore contributed to Mr M22’s son view of Mr M22 *‘falling through the cracks’*. It is recognised that recruitment and retention of nursing staff is a national issue and that Nottinghamshire Healthcare trust is working to establish integrated community teams, which are aimed to improve staff and service resilience and help raise the quality of service. |
| 7.2 | **The importance of Mental Capacity Act (MCA) assessments when dealing with vulnerable patients should be emphasised to staff as a priority. The escalation policies and the availability of online toolkits (self-neglect, non-engagement) and other resources to assist the risk management process should also be highlighted.** This will help inform staff and assist them when completing their risk assessments regarding this type of behaviour.This should also highlight the need for ongoing MCA assessment of patients, particularly in relation to decisions that will be time and decision specific, if it is suspected that there may be some form of impairment. The Trust should ensure that all toolkits are easily accessible, relevant and kept up to date. |
| 7.3 | **Nottinghamshire Safeguarding Adults Board, through the development of their prevention strategy, should promote the importance of holding multi-agency meetings to share information and develop multi-agency risk management plans to manage or mitigate the risks posed to vulnerable adults.** Referral pathways to High-Risk panels should be shared with all the agencies involved and should include all contact details to use when raising a safeguarding alert. Where risk is considered to be unmanageable, agencies should consider escalation options with Safeguarding leads. Measures should be put in place to ensure that cases where self-neglect is suspected are referred to social care prior to the discharge of a person from hospital. |
| 7.4 | **The transfer of care hubs should link in with other agencies where appropriate to ensure that people are properly supported when discharged from the acute setting.** The transfer of care hubs should ensure that all discharge planning is in accordance with national guidelines and that community support services are notified in a timely manner prior to patients being discharges. Clear information should be given to patients about support options available to them, associated costs and whether these can be reimbursed. |
| 7.5 | **Nottingham & Nottinghamshire ICB to progress work on the Eco system plan to evaluate interoperability and information exchange between the Health & Social Care Sector.** This would allow staff to be able to access patient records from other departments so that they have a better idea of what treatment a patient has received, from which department they received that treatment, their current location and details of any discharge plan. This would greatly improve information sharing between the different departments. |
| 7.6 | **Ensure that carers needs in relation to Severe Multiple Disadvantage are recognised as part of the assessment and whole family process utilising a multidisciplinary approach to support people within this group and prevent self-neglect.  Improve data recording to determine the impact of this area on carers and inform future service and support planning.**  If risk factors are shown as being elevated in any of the sections of the carers assessment, then the form should be updated to allow the assessor to justify their evaluation and explain how they intend to mitigate / manage the risks identified. |